Correspondence

The Editorial Board will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words, and must be typewritten, double-spaced and submitted in duplicate (the original typescript and one copy). Authors will be given an opportunity to review any substantial editing or abridgement before publication.

Pneumococcal Pneumonia

TO THE EDITOR: I agree with Smith and Mann[1] in their call in the January issue for accurate data on rates of pneumococcal disease in community hospitals. Unfortunately, their article offers no useful contribution in this regard. In addition to the problem of patient selection, which is inherent in a retrospective analysis (and acknowledged by the authors), the critical reader is faced with a thoroughly inadequate description of the bacteriologic technique used during the period in question. What are "standard culture techniques" as applied to the isolation and identification of *Streptococcus pneumoniae?* Perhaps the board-certified pathologist mentioned in the article is unaware of the voluminous literature attesting to the colossal variability in isolation rates, which are dependent on the methodology utilized. For example, what volume of blood was cultured, using what media and what method? Were selective solid media used and were the specimens incubated anaerobically? Were the plates examined with the use of a stereo microscope?

These and other questions should be answered by the authors in order to make their report evaluable and useful in any comparative analysis.

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REFERENCE

1. Smith FE, Mann JM: Pneumococcal pneumonia: Experience in a community hospital. West J Med 1982 Jan; 136:1-5

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TO THE EDITOR: Smith and Mann[1] reported that pneumococcal pneumonia, particularly bacteremic pneumonia, was uncommon in their patient population in Los Alamos, New Mexico. Several of their methods and results warrant comment.

First, I would question the validity of the data used to conclude that a "reasonable attempt" had been made to establish etiology. Respiratory secretions were cultured in 185 of 230 episodes (80.4 percent). However, as noted by the authors, no quality control was exerted either prospectively or retrospectively. Thus, in addition to the fact that culture of sputum does not distinguish colonization from infection,[2] the question of whether "sputum" specimens were truly representative of lower respiratory tract secretions cannot be resolved.

Second, definitive etiology can be established by culture of blood or lung aspirate. But blood cultures were done in only 95 of 230 patients (41.3 percent). No information is provided as to number of sets of cultures per patient. Since the bacteremia associated with pneumococcal pneumonia is not continuous, the number of times a blood culture is obtained will greatly influence the ability to detect its presence. Lung aspirate was obtained in only one instance.

Third, although review of outpatient use of antibiotics is mentioned in the methods, no data are provided in the results. Since the pneumococcus remains susceptible to most antibiotics that are prescribed in the outpatient setting, it is essential to know how often these drugs may have impaired the ability to detect the pathogen. A more favorable yield can be obtained by using an antimicrobial removal device, but this was not commercially available during the time of the study.

Fourth, the authors seem to conclude that pneumococcal pneumonia is uncommon in their community because of their geography—that is, rural rather than urban. I think a much more important aspect is the character of their patient population. A significant fraction of their community includes workers who are presumably healthy but seek acute medical care in Los Alamos. No data are provided about age distribution or underlying illnesses characteristic of the 17,000 to 25,000 people served by the hospital. In a recently reported retrospective review of bacteremic pneumococcal disease,[3] nature of the place of residence was irrelevant. There are many rural towns in western New York, and 60 percent of our patients come from such communities. The type of patient